



## MedHealth Review, Inc.

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### Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 7/13/12

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of work conditioning 5x per week times 2 weeks, right elbow 97545 and 97546.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)  
☐ Overturned (Disagree)  
☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of work conditioning 5x per week times 2 weeks, right elbow 97545 and 97546.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: Dr., Coventry and.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 6/18/12 denial letter, 6/4/12 denial letter, office notes by Dr. 8/30/11 to 4/28/12, various DWC 73 forms, office notes from Rehab 9/14/11 to 5/23/12, 6/12/12 claims history, 12/2/11 to 12/5/11 notes from Hospital, 12/5/11 neurodiagnostic report, 5/2/12 FCE reports, various PT and work status scripts by Dr., Elbow ODG and 6/27/12 letter by.

Dr. 6/19/12 notes by Dr..

: all records were duplicative of those mentioned above.

A copy of the ODG was provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a worker who was injured on the job xx/xx/xx while employed by. She was removing a box from a machine when her arm was pulled. On xx/xx/xx the worker was seen by Dr. for outpatient follow-up. The worker reported pain radiating to the neck and right elbow. Examination revealed moderate tenderness in the right shoulder and elbow and right upper trapezius and lower cervical spine. X-rays of the right shoulder and elbow were reported to be negative for fracture or dislocation. Dr. diagnosed right shoulder sprain and right elbow sprain and prescribed Mobic, Bio freeze, and no lifting more than 10 pounds, no overhead lifting.

On the follow-up visit 9/06/11 abduction of the shoulder was about 60 degrees. Physical therapy, three times weekly for two weeks, was requested. The physical therapy evaluation was done 9/14/11. At that time the right shoulder flexion was 100 degrees, extension 25 degrees, abduction 78 degrees, abduction -5 degrees, external rotation 40 degrees, internal rotation 55 degrees. Strength was generally grade 4/5 on the right side compared with 5/5 on the left. According to record reviews the worker received a total of six physical therapy visits.

On the follow-up visit 9/19/11 the elbow and shoulder pain persisted. Dr. reported full range of motion to the right elbow and shoulder. He recommended continuing physical therapy and the Relafen and Bio freeze. He considered a possible steroid and ejection if pain persists. On the follow-up visit 10/6/11 worker reported pain in the right wrist and hand. She did not want an injection but said that she would like more physical therapy. Examination revealed normal range of motion of the right elbow. Shoulder abduction was approximately 100 degrees. There was a tinel sign to percussion over the right wrist. A new request for physical therapy was submitted. A tennis elbow strap and right wrist brace were issued.

The worker agreed to have an injection to the right shoulder and elbow October 17, 2011. On the follow-up visit 10/20/11 the worker reported a lot of pain in the right shoulder and elbow and the injection had not helped. She continued to work

with the restrictions as recommended, although she was required to work 10 to 12 hours, six days a week. The physical therapy had not been approved. On 10/24/11 the shoulder forward flexion and abduction had improved to 140 degrees. Pain had decreased from 8/10 to about 4/10. Dr. diagnosed right lateral epicondylitis and right shoulder impingement syndrome. He requested EMG and nerve conduction studies of the right upper extremity. On 11/10/11 the pain persisted. Treatment was continued with Relafen and Bio freeze. Physical therapy had not been authorized. Shoulder forward flexion and abduction were reported to be 85 degrees.

On 11/22/11 the shoulder and elbow pain had not resolved. Grip strength was reported to be equal bilaterally. Right shoulder abduction was 100 degrees. Forward flexion was reported to be intact. Because of the persistence of the symptoms, an MRI of the right shoulder was requested. The MRI was reported to show a large AC joint osteophyte compressing the supraspinatus tendon. The MRI findings were reviewed on the outpatient follow-up visit 12/02/11. EMG and nerve conduction studies were done 12/05/11. On the follow-up outpatient visit 12/05 Dr. summarized the EMG findings which were reported to be consistent with moderate right sensory motor median neuropathy, consistent with clinical diagnosis of right carpal tunnel syndrome. Needle EMG examination of the right upper extremity was reported to be normal.

On the follow-up visit 1/05/12 the grip strength was noted to be decreased on the right compared with the left. Shoulder abduction was approximately 100 degrees. On the follow-up visit 2/06/2012 orthopedic surgery was discussed as an option but the worker did not want that. Prescriptions were given for Relafen, Flexeril and Polar Freeze cream. Physical therapy was again recommended.

On the follow-up visit 3/28/12 the physical therapy had not been approved. An injection was given to the right shoulder and to the lateral humeral epicondyle. On 4/18/12 the worker reported that the injections had not helped very much.

On 5/01/12, right shoulder range of motion was reported to be full, with discomfort past 90 degrees. Dr. requested a functional capacity evaluation. Depending upon the results he would decide the disposition.

On the functional capacity evaluation 5/02/2012 the worker performed at the light strength category, with a maximum lifting capacity of 10 pounds and a maximum carrying capacity of 10 pounds. In order to work in the light strength category, restrictions would be required, including no pushing more than 10 pounds, no pulling more than 15 pounds, no balancing activities that require crouching, and no crawling on the hands and feet. Right shoulder range of motion was limited to 110 degrees of flexion, 30 degrees of extension, 90 degrees of abduction, 5 degrees of abduction, 66 degrees of external rotation and 64 degrees of internal rotation. Grasp and lateral pinch strength were evaluated, but upper extremity

strength measurements were otherwise not reported. Elbow range of motion measurements were not reported.

On the follow-up visit 5/23/11 the functional capacity evaluation results were reviewed. There was right shoulder pain with abduction past 90 degrees. There was pain to palpation over the right lateral humeral epicondyle. Work conditioning was recommended. On 6/04/12 the requested work conditioning five times weekly for two weeks, right elbow, was non-certified. On 6/15/12 after review the proposed treatment was again non-certified.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The documents submitted for review do not contain sufficient screening documentation to meet the criteria for admission to the requested program. The criteria listed below are extracted from the ODG Treatment/Disability Duration Guidelines, Elbow (acute and chronic), updated 05/22/2012, pertaining to Work conditioning, work hardening:

Criterion number 2: screening documentation should include the following:

- Determination of safety issues and accommodation at the place of work injury. As stated elsewhere in the Guidelines, Management of lateral epicondylitis requires a greater focus on interaction with the workplace regarding job modification to reduce physical demands during recovery.
- Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program.

Criterion number 3: Job demands: There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).

Criterion number 6: surgery: The "surgical option" has not been ruled out. The records document that the worker declined orthopedic surgery referral 2/06/12 but there is no further discussion of surgical options. The ODG Guidelines state that for the minority of people with lateral epicondylitis who do not respond to nonoperative treatment, surgical intervention is an option.

Criterion number 15: Concurrently working: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment. The worker reported that she had been required to work longer hours.

All of the criteria are not met in this case. Therefore, the requested service is found to be not medically necessary at this time based upon the records presented.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR  
OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)